the patient could not abduct the arm more than 45 degrees. Danielsen says that in assuming that the shoulders should be forced backward to maintain the reduction, we have been wrong. In a recent case he forced the shoulders forward and maintained them in this position by raising the arm upward so that it lay against the cheek and the forearm was over the head. The arm was bandaged in this position and the dislocation remained reduced. Healing occurred without disturbance and the movements became free and painless.

Treatment of Forward Dislocations of the Clavicle.—BRAATZ (*Zentralbl. f. Chir.*, 1914, xli, 1673) agrees with Danielsen that the generally advised methods of bandaging the arm are wrong, especially the forcing of the shoulders backward, but he obtained complete success by a different method than that employed by Danielsen. He saw the dislocation in a three-year-old boy on the day of the accident. It was easily reduced under narcosis but as soon as the shoulder was pressed backward the dislocation recurred. He placed the arm in the right angled position across the front of the chest without restraint and pressed the shoulder forward. Then over the joint he placed a pad of cotton which was held in place by a strip of adhesive plaster passing obliquely from the back over the shoulder to the left breast. Other adhesive strips were used to reinforce the first and with a bandage the shoulder was fixed in the forward position. A Roentgen ray taken on the following day showed the bones in their normal position. The adhesive was reinforced after fourteen days and a new bandage applied over the whole arm and hand. A Roentgen ray at this time showed the dislocation still completely reduced. The dressing was finally removed at the end of eight weeks and at the end of five months the bones were still in their normal positions. Four weeks retention of the bandage will be sufficient in an adult.

Clinical and Experimental Studies of Hormonal and Neohormonal.—DENCKS (*Deut. Zeitschr. f. Chir.*, 1914, cxxxii, 37) studied the effects of these substances on peristalsis in forty animal experiments and about 140 patients observed at the bedside. The claim of Zuelzer, Dohrn, and Marxer that hormonal is a specific in exciting peristalsis has not been sustained. It is a powerful stimulant of peristalsis in animals and men, as well by intravenous as by intramuscular injections. In favorable cases of chronic constipation, the effect of the preparation has been observed to continue for several years. It frequently fails, however, in animals and men. The dangers associated, which are largely due to lowering of the blood-pressure, have been obviated by an improvement of the preparation, neohormonal. This preparation is indicated in all cases of postoperative disturbance of peristalsis and in all forms of chronic constipation. In mild cases of intestinal paresis and those of moderate severity, the neohormonal may be injected into a muscle. At first 20 c.c. should be injected and if a satisfactory effect is not obtained in four to six hours, a second dose should be given and by preference intravenously. At first 20 c.c. should be injected slowly with the usual syringe, and repeated in four to six hours if a satisfactory result is not obtained. In especially severe cases where a very quick effect is necessary, 30 to 40 c.c. should be injected intravenously and its effect hastened by enemata, applications of heat, etc. In desperately severe cases, the neohormonal should be combined with physostigmin and atropin in large doses. In chronic constipation, 20 c.c. should be injected intravenously, and during the first two to four days should be energetically supported by other purgatives, as castor oil, senna, etc.; if the desired effect is not obtained, in this time, 20 to 40 c.c. more should be injected and this again aided by purgatives. In especially stubborn cases the dose may be increased to 30 c.c. or more. Some of this dose should be given intravenously because the full dose injected into a muscle would cause distressing pain. In children under ten years of age, about half of the above dosage should be tried. The preparation is well borne even in the first year of life. By the employment of sufficiently large doses, according to Denck, failures with postoperative paresis and chronic constipation will be rare.

Intestinal Stasis.—CASE (*Surg., Gynec., and Obst.*, 1914, xix, 592) says that while ileal stasis has been definitely shown to exist in connection with marked obstructing adhesions or kinkings of the terminal ileum, and while it is likely that spasm of the ileocecal sphincteric mechanism may be another factor in the production of ileal stasis, it seems demonstrated that incompetency of the ileocolic valve offers a further and more tangible explanation of ileal stasis and that it is probably the essential causative factor in the majority of cases of stasis in the terminal ileum. Ileocecal valve incompetency is almost always associated with the clinical evidences of intestinal stasis. Not all these patients have, as yet, a well developed alimentary toxemia. His experience in the Roentgen study in these cases of intestinal stasis, both before and after operation, leads him to distinctly oppose the tendency toward operative interference for their relief. Surgery should not be seriously considered as the cure for ileal stasis until a most thoroughgoing trial has been made of the various dietetic and mechanical measures at our command. If an operative measure seems advisable, recognition of ileocolic valve incompetence as a potent cause of ileal stasis may present a course of surgical treatment free not only from the dangers associated with short-circuiting with or without colectomy, but actually calculated to restore normal physiological function.

A Contribution to the Surgery of the Lesser Sac of the Peritoneum.—ZIEMBICKI (*Zentralbl. f. Chir.*, 1914, xli, 1489) gives the following *resumé* of the conditions which have been found in the lesser peritoneal cavity: (1) Hernia through the foramen of Winslow, of which Jeanbrau and v. Riche reported about 20 cases; (2) liver abscess from cholelithiasis through the foramen of Winslow (very rare); (3) blood collections from hemorrhagic pancreatitis or the rupture of an aneurysm of the splenic artery; (4) lymph collections from contusions and wounds, or post-traumatic cysts; (5) blood effusions or inflammation in consequence of pancreatic necrosis with perforation into the lesser peritoneal cavity; (6) pseudo-cysts and pancreatic cysts which develop in the lesser peritoneal cavity. Ziembicki reports 2 cases. In one, operation showed the fluid collection in this cavity to consist of bile. The patient recovered from simple drainage, and this with the fact